THE MILD ENDOGENOUS DEPRESSION*

BY

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In a recent paper on endogenous depression (Watts, 1956) it was suggested that not more than one-quarter of the cases occurring reached the psychiatrist, and that the disease was essentially one of general practice. It is probably one of the most common misdiagnoses, frequently being labelled either an anxiety state or an organic illness. The typical mental-hospital type of endogenous depression is easy to identify. To wait for this severe state of affairs to be reached in order to clinch the diagnosis is like waiting for cavity formation before deciding that a case is one of tuberculosis. There is one big difference between these two diseases. Tuberculosis is a chronic progressive condition which will in time compel recognition, whereas endogenous depression is a self-limiting disease which in 85% of cases remits after a few months or years, and once the patient has recovered the problem of diagnosis is forgotten. Only about one case in every six is a classical deep depression. The other five are milder types, and more difficult to diagnose. Twenty years ago, at the very end of a list of possible aetiologies, one found "hysteria." This clause should be amended to "anxiety states, *endogenous depression,* and other psychiatric disorders."

The first step in making the diagnosis is to realize the possibility. The mild depression has to be sought for. The presenting symptoms in 100 cases are shown in Table I.

TABLE I.—*Presenting Symptoms in* 100 *Cases*

Depression	9	Muscular pains	2
Cough	8	Injury	2
Run down	7	Strange behaviour	2
Insomnia	7	Palpitations	1
Headache	6	Tinnitus	1
Vague complaints	4	Globus hystericus	1
Dyspepsia	4	Urticaria	1
Nervousness	4	Tremor	1
Tight feeling in chest	4	Tonsillitis	1
Giddiness	4	Pseudocyesis	1
Pain in chest	4	Bad smell in nose	1
,, ,, back	3	Piles	1
Belching of wind	3	Diarrhoea	1
Pregnancy	3	Constipation	1
Attempted suicide	3	Haematemesis	1
Vaginal bleeding	3	Collapse	1
Dysuria	2	Dysphagia	1
Fainting	2		

If all the cases with symptoms that could possibly be called neuro-psychiatric are collected together, the total number of the cases will amount to 60% of the whole (Table II). In other words, two-fifths of the cases present as a possible organic disease.

TABLE II

Nervous and psychiatric symptoms	60
Respiratory system	12
Gastro-intestinal system	9
Urogenital system	8
Muscular ,,	5
Ear, nose, and throat system	3
Injury	2
Skin diseases	1
	100

To approach the problem of diagnosis another way, it is suggested that mild endogenous depressions appear in four ways. (1) Some of the patients exhibit overt evidence of a depressive disorder, and the problem is to decide whether the case is endogenous or reactive. (2) Some present as cases of psychiatric disorder, but the depression is heavily disguised. (3) Some present as a "depressive equivalent"; that is to say, the case simulates an organic illness, and the latter has to be excluded before the diagnosis can be made. (4) The depression may be grafted on to genuine organic illness. To illustrate these points, typical cases in the various categories are described.

*This article and its predecessor (Watts, 1956) were the substance of the Sir Charles Hastings Prize essay for 1955.

1. Overt Depression

This kind of case is often presented in general practice as the respectable good patient who suddenly goes "neurotic" and becomes really troublesome. For weeks or months he is a constant attender at the surgery with vague complaints which have no adequate physical basis. He tends to exchange one set of symptoms for another and his outlook is irrational. Then just as suddenly as he started his trips to the surgery, they cease, and once again he becomes the perfect patient, requiring no attention.

A man of 50 presented himself in an apologetic way. He wasn't really ill; he just felt queer. He had never been like it before and just could not understand himself. He could not read as he used to, found it very difficult to make up his mind about things, was restless, and could not sleep, having difficulty in dropping off. There was no obvious reason for any anxiety or depression. Testosterone was ineffective, but he found great help from quinalbarbitone on retiring and dexamphetamine in the mornings. He was unable to work for four weeks, and when better admitted he had had ideas of poverty he had never spoken about. When seen six months later he had quite recovered.

A woman in her forties was very prone to this condition. She usually came to the surgery with some fairly trivial complaint, but if given a sympathetic ear she was prepared to pour out her troubles. "Doctor, I don't know what is the matter with me. I have a good husband, a nice home, and three lovely children. I have everything that a woman can want and yet I'm utterly miserable."

A married woman aged 44 came to see me because of dizzy bouts. She said she could not understand herself, as the least thing upset her. Some days she felt on top of the world, and the next useless. She kept waking up in the early hours of the morning and what sleep she had was broken with bad dreams. She could not concentrate, and found her memory was going. She could not settle to do jobs which at one time gave her great satisfaction. There was no wish to be dead, but she was given to weeping bouts.

2. Depression Disguised as an Anxiety State

The following case illustrates the difficulty in making a diagnosis. While three doctors were agreed on the psychogenic nature of the problem it was not until psychotherapy was started that the case was shown to be one of endogenous depression.

A man of 31 was passed on to me as a psychiatric case by one of my partners. He had already been seen at the hospital out-patient department, where the diagnosis was considered to be "psychogenic." His story was that in June, 1955, while working a crane, a giddy feeling came over him and he had palpitations. He felt very frightened and thought he might drop dead. He had been sleeping badly for some time before this attack. When seen by me in February, 1956, he was complaining of headaches and vertigo, and my first diagnosis was one of anxiety state. Financial worry seemed to offer some explanation for his troubles, but he had no insight into his condition and he was unresponsive to psychotherapy. Attention was then turned to probe for depressive feelings. Inquiry showed that he was in very low spirits and often wished he was dead. He felt it was all his own fault that he had allowed himself to slip, and he had distinct ideas of guilt. Powers of concentration had gone, he could no longer read books,

and noise upset him. He found the children a problem and the wireless unbearable. The world, he said, looked different, a less pleasant place than it had been. He was referred to a psychiatrist, who agreed with the diagnosis, and he entered a mental hospital as a voluntary patient.

3. The Depressive Equivalent

The type of case in which the depression simulates an organic illness was called by Kraines (1943) a depressive equivalent. A selection of these cases is given to illustrate how deceptive the disease can be, and not because equivalents are more numerous than other types of depression.

Simulating Gastric Carcinoma.—A man aged 52 sent for me in August, 1946, because he had had a haematemesis. I did not see the blood, but he was obviously very ill. He was pale but not exsanguinated. He had a marked anorexia, was very thin, but had no pain whatsoever. I could find no physical signs in his abdomen, but I suspected carcinoma of the stomach. As soon as he was fit enough he was sent for *x*-ray examination, with negative results. In November he was a living skeleton. He could not sleep, and felt awful in the mornings. He was morose and could not bring himself to speak to his family. He admitted he was very depressed, and when I asked him if he wished he was dead he replied, "I have indeed, but I would never have told you had you not asked me." He stated he still could eat nothing before dinner, but felt better by evening. At bedtime he felt much better, but could not get off to sleep. This morning depression and evening vigour is fairly common in melancholics. A week later he was very depressed and admitted that but for his family responsibilities he would get out of it. I persuaded him to see a psychiatrist, who reported as follows: "This patient has, as you say, a typical involutional depression of something like 12 months' duration. He should have E.C.T., but refused to go to a mental hospital. His haemorrhage is indeed difficult to account for, though it did follow vomiting. Did the strain of retching rupture a vessel?" The patient was very satisfied with this second opinion, although he poured scorn on the idea of a mental hospital. By July, 1947, he had recovered enough to go back to work.

This man presented a typical picture of gastric neoplasia : but he proved to be a case of depression.

Simulating Asthma.—An old man of 84 sent for me because he was having attacks of nocturnal dyspnoea. I found him setting potatoes in his garden, so he was by no means an invalid. He actually lived alone and cared for himself. His story was that at 2 a.m. he awakened short of breath. He had to get out of bed and open the window, and there was no more sleep. I thought he probably had cardiac asthma, but there was no evidence of either heart or kidney disease. Linctus and cough medicines were ineffective in helping his dyspnoea. He pressed me to let him know the worst, and all his family felt it was the end. The early waking and his deep concern over himself made me suspect depression. I gave him a barbiturate hypnotic each night, and once his sleep had returned to normal he greatly improved. He never had a return of his symptoms and he lived to the ripe old age of 92.

I have called this incident a depression. It was certainly no organic or progressive disease. There was no history of asthma, and I never found any evidence of bronchospasm. He had a very fine health record. My view is that this was a very mild depression which fortunately came and went fairly quickly, lasting in all about two months.

Simulating Rectal Growth.—A man aged 45 came to see me in February, 1947, complaining of diarrhoea. His stools were running from him in the surgery, so that I had to send him home and go there to examine him. There was a history of alternating diarrhoea and constipation with marked loss of weight. Nothing was found on physical examination either per rectum or per abdomen. He was referred to hospital, where investigations were again negative, but it was suggested he be kept under observation. A month later, when his diarrhoea had ceased, he complained of difficulty in falling off to sleep, bad dreams, and awaking unrefreshed. He said he felt awful in the mornings and had done so for at least three months. Everything was too much trouble; but he denied being depressed. He was irritable at home and his sexual desires had gone. I returned him to hospital with the suggestion that he was depressed. This view was confirmed by the physician. By April he was worse, neither eating nor sleeping. In May his wife came to see me. She was very worried about him and was sure he was suicidal. She agreed to his going to a mental hospital, but we could not persuade him to go. Fortunately he began to improve, and by July was back at work, having been "on the club" for five months.

Simulating Intestinal Obstruction.—A woman aged 57 came to see me in April, 1947, complaining of abdominal pain. Physical examination revealed that her abdomen was distended, and she presented a picture of subacute obstruction. I sent her to see a surgeon privately, and he admitted her to hospital at once and performed a laparotomy, to find nothing abnormal. I saw her again in May, when she came out of hospital. All her abdominal symptoms had gone and she complained of insomnia, early waking in character. She was depressed and lacrimose, but admitted no death wish. Her memory was bad and she could not stand noise. She told me she had been very depressed 27 years previously, after the death of a child. She had visited the grave twice daily and once filled a tub in which to drown herself. A week after this interview she was somewhat better, having good days and bad days. The depression gradually lifted, and in October, 1947, she said she would not come again as she was quite well, and her recovery appears to have been maintained for the past nine years.

This case is of interest because the depression did not become obvious until after the laparotomy; but it must have given rise to the obstructive signs and symptoms. Autonomic upsets are not infrequent in depressive illness, as shown by sweating, tremors, fainting, and even ague.

4. Depressive Grafts

In my opinion few chronic sick are more cheerful in adversity than the victims of severe forms of rheumatism.

A man of 27 had been confined to his bed for seven years with a poker back and ankylosing arthritis of both his hips. He was usually cheerful and contented in spite of his crippling and sometimes painful complaint. He seemed to have accepted the bad prognosis and adjusted himself to the limited little world in which he was compelled to live. He revelled in the praise he got from his family and friends for his uncomplaining attitude. His bedside became a social centre. But periodically a cloud descended and he lost his tranquil frame of mind. He grew restless and demanded further investigation of his condition or a new treatment. He became complaining, morose, and difficult to live with. He felt his life in his deplorable state was not worth living, and suicidal ideas were not far away. He was broody and had difficulty in sleeping. He refused to eat, was depressed, and at times lacrimose. He was full of symptoms, and each new pain had an ominous significance. His whole attitude to his suffering became illogical and quite the reverse of his usual fortitude.

I saw this man in only one of his attacks, but my partner, who had been looking after him ever since his illness began, said he had had three or four similar attacks. These usually last for about a month, and then the cloud lifts and he becomes his old self again, seemingly adjusted to his physical limitations.

A man of 64 had very severe chronic bronchitis and marked emphysema. Only on his best days could he walk very slowly along the village street. Most of his life was spent in his chair in the kitchen. He was a man of character. Starting life as a collier, he had continued at that work until his chest had stopped him five years previously. But besides his mining he had saved money and bought property. He was a fine gardener and owned a sizable poultry farm. He was always an interesting man to visit, although he was

so short of breath that even speech was difficult at times. He was philosophical about his illness, and usually said little about it. He preferred to talk about gardening or hens. When I called to see him in March, 1946, he had left his place in the kitchen and was sitting in a chair in his downstairs bedroom. He looked thoroughly miserable and depressed. He felt his end had come, and, although he had no ideas of suicide, he wished he could die. Life was a burden to him and he could see no future. His sleep was bad, as he was given to early waking. He made a good response to phenobarbitone and amphetamine, and in about three weeks the depression had passed. He came back to the kitchen and was his old cheerful self until he died in an emphysematous crisis some eight months later.

A married woman of exceptional personality and ability lived alone and did all her own housework at the age of 82. In August, 1947, I was called out to see her in the night as she had an attack of renal colic. I gave her morphine, and the next day she was much better. I noticed she had auricular fibrillation and a fast pulse, so I kept her in bed for a few days. She developed oedema and became seriously ill. Her son took her to his home, and there she became very depressed. She did not weep, but felt she was finished, and actually asked me to put her away. She could neither eat nor sleep, and it was difficult to control her oedema. Slowly she improved, but she remained profoundly depressed. In ordinary times she knitted, did the *Daily Telegraph* crossword puzzle every day, and enjoyed jigsaw puzzles, but she could settle to none of these things. She even lost interest in her own home, and she had always been of a very independent nature. Just after Christmas she was persuaded to go to her other son in a distant town for a few weeks. She hated every minute of the change and must have been a very difficult guest. The doctor who looked after her wrote and told me that, while her fibrillation was under control, she was very much a "cracked pot." She came back in February, and an improvement soon became obvious. She had started knitting and listening to the wireless. By Easter she was well enough to go home and take up her own life again, including her crossword puzzles. She kept remarkably well for two years and then had a stroke and died in two days.

Symptomatology

The severe depression is expressed in the triad of symptoms—namely, difficulty in thinking, depression, and psychomotor retardation. In the profound case these are often obvious at a glance, but with mild cases they have to be sought for.

Difficulty in Thinking

This is expressed in the patient with mild depression in two different ways. First, as a feeling of tiredness and exhaustion. The "reading test" is quite a useful measure of its magnitude. The reader of books finds he cannot concentrate enough to enjoy a book, but he can read the newspaper. Patients with more severe depression cannot even take an interest in the newspaper. One collier who could raise enough interest at midday to drink his beer and make a bet, could not by nightfall raise the interest to look at the results in the evening paper.

The second way in which this basic symptom is expressed is an illogical approach to the problem. As Robert Burton (1628) put it 300 years ago, "Reason as well as imagination is at fault." One man blamed a quarrel with the foreman for his troubles. Argument could not convince him that this explanation was phony, but a week later he decided that the real cause of his trouble was he needed glasses. The quarrel was forgotten. Often there is an element of self-blame in these phony explanations. An engineer blamed worry over a haulage cable which he had not tested to his satisfaction, but there was no real evidence that his fear about the cable was valid. He could never forgive himself if it ever broke. The mind of the anxious patient is rational and he can follow with interest a logical argument. That of the depressed patient is irrational. His thoughts and ideas are repetitive. He will say the same thing over again, and ask the same questions; he makes no progress with superficial psychotherapy.

Depression

The victim of a mild depression does not look depressed, but he will readily admit he feels in low spirits. The colour has gone out of life, and the future, if not black, is at least grey. The sense of humour goes. He "is not himself" in a very real way, and he feels isolated and misunderstood. The tolerance of noise drops in depression, and, as wireless is an almost universal noisemaker, the patient's reaction to it is significant. The patient who used to work to a background of wireless programmes now switches the set off. The row made by his children upsets him in a way it never used to.

1. *Suicidal Ideas.*—These ideas are an expression of this symptom. In a depressive with suicidal feelings the depression is not mild, but even in the mild cases the seeds of the suicidal urge may be evident. This is expressed first as a fear of dying. The patient feels he has some mortal illness such as cancer or tuberculosis, or he is going to have a stroke. This same feeling may be expressed not as a fear of any disease, but as a feeling of apprehension as if something terrible is going to happen. "Every time a car stops outside, I think they are bringing my husband back from the mine," or, "Every time the 'phone rings I feel it is bad news." As the depression deepens, the patient expresses not so much a fear of death as a wish to be dead. This is still not the same as a true suicidal urge which occurs in the worst types of depression. If a true suicidal urge is suspected the patient should be sent to a mental hospital for treatment. Occasionally even the apparently mild depressive may be more suicidal than one thinks.

2. *Phobias and Obsessions.*—Just as the suicidal urge has forerunners in such symptoms as a fear of impending disaster, a fear of death, or a wish to be dead, so the frank delusions of the profound depressive may start as simple phobias or obsessions. A fear of venereal disease is a not uncommon symptom of depression.

One of the village fathers, a venerable man of 65, came to ask me for a tonic, as he was run down. His symptoms were all very vague and indefinite. During this first consultation he confided in me that as a young man he had had gonorrhoea. He concluded by saying, "I have never told anyone about that before. I have been wondering lately what my children would say if they knew, or what my friends and their wives would think of me." This was in fact the beginning of a depression which lasted for about three months. Soon after recovery he had a coronary thrombosis which ultimately killed him, but during the physical illness he was never morbid or depressed, and no mention was ever made of venereal disease.

The phobia which persists may become an obsession, so that the patient can think of nothing else. The obsession may be about disease, as in a case of cancerophobia, or it may be about some misdeed, as in the case of a mother who felt she had killed her child. Phobias are common among mild depressives, but if the patient becomes obsessed the depression is getting deeper, and it is as well to get the advice of a psychiatrist, as such cases often need E.C.T.

3. *Insomnia.*—This in one form or another is an essential feature of endogenous depression. While the most common form of sleeplessness is that the patient awakens in the early hours, this is by no means always true. When a series of 100 cases was analysed early-waking insomnia was evident in only 44% of the patients. A more general form of insomnia is not uncommon. The patient finds difficulty in getting off to sleep, and, once asleep, sleeps only fitfully, to wake in the morning more exhausted than when he went to bed. A further 22% had difficulty in dropping off to sleep, but then slept reasonably well. Most patients with endogenous depression awaken with a heavy head and they feel useless for several hours. Bad dreams occurred in 21% of the cases, and in two the dreams were so awful as to account for the insomnia. "I dream of terrible and shameful things," "I never had such dreams in my life," or, "I am always

dreaming of death and dead people," are examples of how such dreams are described. Two patients could not sleep because of their bad coughs, and another woman, who was suffering from pseudocyesis, was unable to sleep because of the "movements inside her."

Psychomotor Retardation

In the case of mild depression psychomotor retardation may be expressed by minor habit changes. This symptom is a most subtle measure of depression. It happens for a variety of reasons. Sometimes the habit change is because there is a falling off of powers of concentration and application. The pianist never opens her piano, and the keen gardener lets his weeds grow unheeded. The tidy person tends to neglect personal hygiene and look unkempt, but with mild depression this is not likely to be marked.

The social habits of the patient are very prone to alter. The normally affable person tends to stay at home because people are apt to ask questions about his health or pass remarks about him which only make him more depressed. The music-hall and the cinema no longer amuse him, and his inability to laugh with others only underlines his troubles. On the other hand, some timid normal unsociable types begin to seek company. They are so fearful of their own thoughts that they prefer and feel safer with other people.

Bizarre forms occasionally arise. One depressed woman who was obsessed with the idea of a growth in her back used to wear holes in all her clothing by rubbing the affected part against suitable articles of furniture. The habit was noticed long before the depression was diagnosed or the reason for the back-rubbing was elucidated. Another reason for habit changes is that the patient is always on the look-out for an explanation for his symptoms, and, like the drowning man, he will clutch at a straw. If he happens to blame the habit of a lifetime for his symptoms, it is dropped. One man of 56 ceased to take his ritual purge on Sundays in case that was upsetting him. The regular drinker may stop drinking, or he may drink a lot more in order to obliterate his unpleasant feelings. One thoroughly reliable and normally abstemious patient developed delirium tremens, as he took to relying on alcohol to get him off to sleep.

The Feel of the Case

The classical melancholic oozes depression, so that the observer feels depressed himself, in much the same way as the merry "drunk" readily transmits his cheerful state of mind to responsive company. There is no aura of depression about mild cases, and yet they have a definite quality of their own. Their attitude of mind is one of *injured bewilderment*. "Why am I like this"; "I have never been like this before in my life"; "I don't know what has come over me"—all these are the patient's ways of describing his feelings. He is pained and worried by his change of outlook. He seems to want reassurance, but does not appear to accept it at the time, as with monotonous regularity he goes over his symptoms again and again. He is in fact assisted by reassurance.

A man of 56 appeared to have a mild depression. After a full history and careful examination he was reassured, and the disease was explained to him. He was told that in a few weeks, or perhaps months, his troubles would all disappear. He was seen weekly for some time and then six months later he came down to the surgery. He had quite recovered, but was still able to give a vivid description of his depressive feelings. He had felt hopeless, and the doctor's reassurance, although viewed with considerable doubt and misgiving when it was given, had helped. In fact, now that he was well he was prepared to admit that all forecasts of recovery, disbelieved at the time, had been fulfilled, and he was grateful for such reassurance.

The depressed mind, besides being somewhat rigid, appears to work in an illogical manner. The melancholic is unimpressed by a reasoned explanation of his feelings. He may, in fact, feel worse if told too much. On the other hand, a perfectly intelligent depressive will ascribe his state to quite absurd possibilities. An innocent pimple has fearful significance, some distant peccadillo is now bringing retribution, and so on. In spite of this rather difficult frame of mind, the patient is at heart grateful for all attention and sympathy. One woman who has in eight years had five severe but short-lived depressions comes along or sends to the doctor if she feels an attack coming on. She must know by now that no medicine the doctor can give her will help. She evidently feels that his knowledge of her suffering and his understanding in some way help to make the burden lighter. Even if the recurrent case knows it may lead him back to a mental hospital, he usually comes back to his doctor when he feels the clouds are descending on him.

Treatment of the Mild Depression

The factors which should make the general practitioner pass a depressive case on to the psychiatrist are twofold. First, if he can detect a suicidal urge, or symptoms such as agitation or delusions are emerging, then the depression is no longer mild, and E.C.T. is probably indicated. Secondly, if the illness lasts more than three months, further advice should be sought, to confirm the diagnosis and to consider physical treatment. If these two points are borne in mind the treatment of the mild types of depression is safe and simple and within the scope of general practice.

The most important factor in treatment is to establish a good rapport. The patient is so often spurned and misunderstood, especially by well-meaning relatives, that it is a great relief for him to find a sympathetic ear. His feelings of guilt, if not overt, are latent, and he tends to feel a very inferior creature and thoroughly ashamed of his symptoms. The doctor who can assure him he is suffering from a common and well-understood disease makes him feel less lonely. If added to this the practitioner can show real interest and encourage him to come again once or twice each week, the patient is greatly relieved. He expects to feel he is a burden, a waster of the doctor's time. Have not his family told him that only he himself can help himself? He comes to the surgery expecting to be snubbed and feeling that the busy doctor will have no time for cases such as his. To find himself the centre of interest and understanding is a pleasant surprise in the grey world of depression.

Symptomatic Treatment

Insomnia is the most obvious symptom to treat. Barbiturates have a wide range of action. For the early-waking types butobarbitone, 3–6 gr. (0.2–0.4 g.), is indicated. Barbitone sodium, 7½–10 gr. (0.5–0.65 g.), is very useful, but it is so prolonged in its action that it tends to cause a hangover the following day. For those who have difficulty in dropping off to sleep the quick-acting barbiturates such as quinalbarbitone, 1½–4½ gr. (0.1–0.3 g.), should be given. The general insomnia or fitful sleep needs a mixture of both, such as quinalbarbitone, 1½ gr. (0.1 g.), and barbitone sodium, 7½ gr. (0.5 g.). Hypnotics should be looked on as a temporary measure, and if a habit is being formed the patient should be switched to the safer and less appetizing chloral hydrate, 30 gr. (2 g.). All hypnotics should ideally be given to a relative, who should administer them to the patient and see that he takes them, as the capsules and tablets are such an easy method for the would-be suicide. This is a council of perfection. It should be applied to the moderate and severe cases, but the patient with mild depression rarely brings a relative: the ritual of bringing the next of kin, and giving him a private session to discuss the patient's symptoms, and so on, only tend to increase the patient's apprehension about his troubles. In a series of 289 cases of endogenous depression four actually did use the barbiturates with suicidal intent. Only one patient was seriously ill and eventually died. On the other hand, it must be admitted that three of the four cases were viewed before this episode as cases of mild depression. In the early stages, when the patient is being seen twice weekly, the drugs need only be prescribed in small quantities to last three or four days.

As euphoriants and dispellers of the morning headache the amphetamine group of drugs are still the most useful. In a small proportion of cases, probably not more than one in ten, they work like a charm, and yet in others serve no useful purpose. They can be used in combination with barbiturates or aspirin in certain cases.

Malleson (1953) recommends the use of small doses of natural oestrone, ethisterone, and methyltestosterone in cases of premenstrual and menopausal depressions. If one hormone fails to work another is tried, or two are tried alternately. No adequate series has so far been established, but a few most gratifying results have been recorded, and further work on the subject is certainly indicated. There are many drugs on the market which claim to be useful in cases of depression, such as rauwolfia, chlorpromazine hydrochloride, pipradrol hydrochloride, benactyzine, and methyl phenidate hydrochloride, but again none have been given an adequate trial so far in the mild depressions of general practice.

Light work or work devoid of responsibility is to be encouraged, but the patient should not be physically exhausted by his labours, or weighed down by an overactive sense of duty. If work is a burden, it should be abandoned for a while. A change of scenery or company may help those with a mild depression, whereas it is definitely contraindicated in those with the severe type, who need to be kept under constant observation. Very few housewives, who form a big proportion of these cases, ever allow themselves to be put off work altogether.

Summary

The mild endogenous depression accounts for 60% of the cases which occur. The symptoms are usually so mild that the patient is not likely to get past his general practitioner into the hands of a psychiatrist. It is essentially a disease of general practice. The condition is frequently disguised, and is often misdiagnosed either as an anxiety state or as an organic illness. It can also occur as a graft on to established organic disease, and if such a patient is to receive adequate treatment the depression must have due recognition. These disguised forms of endogenous depression are illustrated by typical cases. The severe mental-hospital type of depression, with the classical triad of symptoms, is easy to diagnose. The case of mild depression has to be sought out. Difficulty in thinking, depression, and psychomotor retardation are all evident in an early and modified form. The evolution of such symptoms as suicidal ideas and delusions is observed in the various grades of depression. The mild depression has a distinct "feel" of its own. The patient presents a picture of "injured bewilderment."

Most of these mild cases can be treated at general-practice level. If a suicidal urge emerges, or the patient becomes agitated or deluded, a psychiatrist should be called in. It is as well to pass even a mild uncomplicated case on to a specialist if the depression shows no signs of improvement after three months' observation.

Symptomatic treatment is described, but the most potent weapon in the hands of the general practitioner is a good rapport with his patient. The sympathetic understanding of the doctor goes a long way to tide him over the dreary and painful weeks or months of depression. This is confirmed by the way in which patients with recurrent depression come back as soon as they feel the clouds descending.

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TRIAL OF RESERPINE IN TREATMENT OF SCHIZOPHRENIA

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This is a report on the immediate results of a clinical trial of the use of reserpine in the treatment of 119 cases of schizophrenia. The study covers a period of 18 months. An assessment of the cases was made on December 31, 1955. Only patients whose response to the drug was regarded as decisive by this date were included. The follow-up period ranges from a few weeks to ten months.

Inquiry into the efficacy of a new treatment in psychiatry is notoriously difficult. A controlled investigation satisfactory to statisticians is difficult to obtain, especially with a drug which has marked side-effects. Psychiatric diagnosis is inexact, and descriptive terms may have widely different meanings for different psychiatrists. The natural illness is often fluctuating and subject to remission. Enthusiasm for a new treatment, a new interest in the patient, and a favourable change in the environment can all react markedly on the patient, and influence results.

We have divided our cases into five groups, and the order in which we report on them reflects the history of our attitude to the drug. Thus the first group consists of chronic deteriorated patients who were long since regarded as past any hope of improvement. Results with this group encouraged us to treat a group of cases which had failed to respond satisfactorily to other better-tried methods of treatment. Later, we used the drug as the first line of treatment in cases considered unlikely to respond to these better-known methods. Finally, we report the results in two groups of acute cases in which the immediate prognosis with other methods had been thought likely to be good.

Regime of Treatment

The preparation of reserpine used throughout the trial is marketed under the trade name "serpasil."

When we began to use reserpine it was available only in tablet form, and in group I the dosage varied from 2 to 8 mg. daily by mouth. In the other groups we were guided by Kline's scale of dosage (Kline and Stanley, 1955; Barsa and Kline, 1955), and the following amounts were used: 3 mg. orally daily throughout; 5 mg. intramuscularly on the first evening; and 10 mg. intramuscularly nightly for three to seven weeks, reducing this to 5 mg. on alternate nights for two weeks, and finally 2.5 mg. on alternate nights before discontinuing the injections. If side-effects were troublesome the dosage was reduced earlier. In the most severely and chronically ill the intramuscular dosage was continued as a maintenance dose on every second or third night indefinitely. The giving of the injections at night minimizes absenteeism, due to side-effects, from occupational therapy classes and recreational and social events. Each case must be treated individually, and dosage modified according to the side-effects and the mental